Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $11,040.00 for dates of service 05/14/01 through 06/19/01.

   b. The request was received on 04/26/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 05/25/02
   b. HCFA(s)
   c. TWCC 62 forms
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 06/13/02
   b. HCFA(s)
   c. TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 05/31/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/03/02. The response from the insurance carrier was received in the Division on 06/17/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   "Enclosed you will find the TWCC 60, TWCC 60 Table, as well as HCFA's, Explantion of Benefits, and clinical notes for the Dates of Service in dispute. Because there is no set fee guideline for chronic pain management in the 1996 Medical Fee Guidelines, we feel that the $180.00 per hour that is billed by the (Provider) is fair and reasonable. Our program is billed under 97799 CP, as unlisted physical medicine/rehabilitation service or procedure."

2. Respondent:

   "Carrier reduced the reimbursement for provider's charges to a fair and reasonable amount as noted in its EOBs. **Exhibit A.** It appears that Provider is not CARF approved, and since the services rendered were for chronic pain management, carrier pays a maximum of $92.00 per hour. In addition, for DOS 6/18/01 and 6/19/01, carrier denied payment because the provider failed to adequately document and substantiate the level of service provided and did not do so in its Request."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/14/01 extending through 06/19/01.

2. The carrier's EOB denial submitted is "M-REIMBURSED PER THE INSURANCE CARRIERS FAIR AND REASONABLE ALLOWANCE. N-NOT APPROPRIATELY DOCUMENTED REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
05/14/01	97799-CP-AP	$1,260.00 (7.0 units)	$644.00	M	DOP	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i) & 133.305 (i) MFG;MGR (II)(C)(G) MFG GI (III)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that indicates a higher rate of reimbursement. The issue is what is "fair and reasonable" reimbursement for the services rendered. The referenced GI states, "…(DOP) in the …(MAR) column indicates that the value of this service shall be determined by written documentation…" The burden is on the Requestor to show that the amount of reimbursement requested is "fair and reasonable." The provider is a non- CARF accredited facility. The provider billed in accordance with the referenced Rule and medical documentation indicates that the services were rendered. Regardless of the carrier's lack of methodology and response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. In light of recent SOAH decisions, where providers have submitted EOBs for documenting fair and reasonable reimbursements, SOAH has placed minimal value on EOBs for documenting fair and reasonable. The willingness of some carriers to reimburse at or near the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011 (d) of the Texas Labor Code. Therefore, additional reimbursement is not recommended. For the dates of service 06/18/01 and 06/19/01 denied "N", medical documentation supports the services rendered and reimbursement is recommended in the amount of $92.00 per hour, the amount carrier reimbursed for the other dates of service as fair and reasonable. ($92.00 x 8.0 units billed = $736.00). Therefore reimbursement is recommended in the amount of **$736.00**.
05/15/01		$720.00 (4.0 units)	$368.00	M			
05/16/01		$540.00 (3.0 units)	$0.00	M			
05/17/01		$1,260.00 (7.0 units)	$644.00	M			
05/21/01		$1,260.00 (7.0 units)	$644.00	M			
05/22/01		$1,260.00 (7.0 units)	$644.00	M			
05/23/01		$1,260.00 (7.0 units)	$260.00	M			
05/24/01		$720.00 (4.0 units)	$368.00	M			
05/29/01		$1,260.00 (7.0 units)	$644.00	M			
05/30/01		$1,260.00 (7.0 units)	$644.00	M			
05/31/01		$1,260.00 (7.0 units)	$644.00	M			
06/04/01		$1,260.00 (7.0 units)	$644.00	M			
06/05/01		$1,260.00 (7.0 units)	$644.00	M			
06/06/01		$1,260.00 (7.0 units)	$644.00	M			
06/07/01		$1,260.00 (7.0 units)	$644.00	M			
06/11/01		$1,260.00 (7.0 units)	$644.00	M			
06/12/01		$1,260.00 (7.0 units)	$644.00	M			
06/14/01		$1,260.00 (7.0 units)	$644.00	M			
06/18/01		$720.00 (4.0 units)	$0.00	N			
06/19/01		$720.00 (4.0 units)	$0.00	N			
Totals		$23,580.00	$12,540.00				The Requestor **is** entitled to additional reimbursement in the amount of **$736.00** for the dates of service 06/18/01 and 06/19/01.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $736.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 18th day of July, 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.